Decolonizing Global Health in Practice: An analysis of the Afrique One-ASPIRE initiative

The discourse around Decolonizing Global Health (DGH) is as diverse as the experts and leaders engaging in it; there is not one single perspective on how it should be achieved. However, every voice in the movement seems to be in agreement: the majority of global health work today continues to reflect the same power dynamics and colonial thinking that existed during the time of its birth as tropical medicine [1, 2].

In this paper, I will summarize three key imperatives from DGH advocates for global health practitioners and organizations, and with this framework in mind, I will analyze a relatively new initiative, Afrique One-ASPIRE, to explore its model of engagement in global health work. Is this initiative a step in the right direction or does it perpetuate more of the same patterns we have seen? I will refer often to the work of Dr. Seye Abimbola, an associate professor of health systems based in Sydney, Australia and a prominent voice in the DGH movement [3, 4].

What does it mean to decolonize global health?

Decolonizing global health refers to the dismantling of the inherent power hierarchy, imbalance, and inequity that exist within the global health space. The modern field of global health originated in colonial efforts to reduce mortality and prevent the spread of diseases, such as malaria, in 'tropical' colonies (particularly, but not exclusively, in Africa) [2, 5]. These epidemiological programs of the 19th and 20th centuries – collectively making up the field of 'tropical medicine' – served the interests of the colonial rulers, without consideration of the local people affected, and served to protect those traveling to the colonial territories. While the field has evolved several times since, the origins of colonial engagement and infringement in countries of the global 'South' still reveal themselves in the funding structures, power dynamics, and leadership of the field today [1]. As Dr. Abimbola and Dr. Madhukar Pai, an Indian medical doctor and advocate specializing in tuberculosis and based in Canada, put it, "to decolonize global health is to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level" [1].

So, what needs to be done? From the work of Dr. Abimbola and his colleagues in multiple publications, we draw three key calls-to-action that may move the field forward towards decolonization [3, 4].[1] It is important to note that this list is certainly not exhaustive, and it is indeed an interpretation of the discourse.

[1] Agnes Binagwaho, former Minister of Health for Rwanda and current Vice Chancellor of the University of Global Health Equity in Rwanda, has made the important point that while the movement is largely known as

The first imperative is a call for "*real* diversity, equity, and inclusion" (DEI) [3]. Today, a majority of the leading organizations in the field of global health are headed by experts from high-income countries (HICs), rather than by experts from the countries in which the programs or initiatives are being held [3]. Decision-makers are often headquartered in, or are themselves from, HICs in Europe and North America; studies cite 80% of global health organization leaders are from HICs and an even larger proportion were educated in HICs [3]. Many efforts towards DEI in recent years, such as the creation of committees and the consideration of DEI in job applications, have been surface-level. In order to commit fully to DEI, organizations need to make structural and processual changes to not only make space for members of low- and middle-income countries (LMICs) to be in decision-making positions, but to also embed DEI into their mandates and policies [3]. Ultimately, the leaders in charge of funding and agenda-setting decisions should be reflective of the populations served, should have lived experiences in the settings in which the work functions, should have diversity in perspectives, and should be selected with input from local stakeholders [4].

Secondly, global health practice should rely on and invest in local knowledge, practices, and research [3]. Dr. Abimbola and Dr. Pai imagine that in a future where global health is decolonized, organizations are led by those who are closest to the work and the issues, and local knowledge takes precedence [1]. As Agnes Binagwaho, former Minister of Health of Rwanda, put it, partners in HICs "really believe that they can help us in malaria program design when we are the experts…they don't trust our school of public health. They don't trust our knowledge. And they trust [that] they will manage better for us when, doing so, more than 60 percent of money will remain there and not serve the purpose for which they received the money" [6]. In fact, some figures estimate this proportion of money (that does not go to local communities) to be even higher. For example, studies have shown that only 2% of humanitarian aid funding goes to local NGOs, and at least 70% of some of the major funding schemes of global health work go to organizations based in HICs [3, 7].

decolonizing global health, she prefers to label it as "a movement to fight white supremacy in global health" [6]. Colonialism is just one manifestation of white supremacy, which permeates so much of our societies. When we refer to high-income/low-income countries, global North/South, and other dichotomies, it is important to remember that white supremacy is the backdrop of the conversation around DGH.

Consequently, structures for funding global health work is the third imperative identified [3]. In the current reality of funding structures, efficiency is often lost, trust is not built between stakeholders and donors, and conditions for funding are often not aligned with the reality on the ground [3]. In May 2021, Ngozi A. Erondu, a Nigerian infectious disease epidemiologist and global health policy expert, and her colleagues wrote an open letter on this topic, specifically drawing attention to a recent grant for 30 million USD towards malaria control in Africa, except no African partners or stakeholders were named or involved publicly [8]. This is just one example of the ways in which funding structures, and thus priority and agenda-setting decisions, exclude the local communities involved in carrying out the work. Furthermore, the short nature of many funding cycles prevents truly sustainable work rooted in organic change, and leads to an emphasis by donors and funders on easily achievable, cost-effective wins.

> *"If you give US $30 million to 30 universities in Africa…the impact they would have is greater than you are going to see from this kind of skewed initiative where maybe 70% of the funding is going to go to overheads and it will never reach the national malaria control programmes....this is still acceptable?"*
>
> *- Catherine Kyobutungi, Executive Director of the African Population and Health Research Center in Kenya and co-author of the open letter [6]*

Applying the concepts: Afrique One-ASPIRE

It is clear that structural and fundamental change is needed to reshape the field, and it can be useful to look to models of global health work that seem to embody these principles. The Afrique One-ASPIRE initiative is pioneering an approach to disease research that is sustainable and locally-owned. While the consortium was originally funded by the Wellcome Trust's Africa Institution Initiative from 2009 until 2016, the project today known as Afrique One – African Science Partnership for Intervention Research Excellence (ASPIRE), is completely African-led by nine institutions across the continent, and partners with five African organizations and two European institutions, in Basel and Glasgow [13]. The initiative is aimed at tackling zoonotic diseases endemic in Africa, such as rabies and brucellosis, by building Pan-African capacity across East and West Africa (note the bilingual name for the initiative) [13].

The Afrique One-ASPIRE initiative, despite originally having high involvement from HICs, is today completely African-owned. The decisions are being made where the work is being done, by the people doing the work, and this is a crucial step for reimagining global health in a decolonized way. Afrique One-ASPIRE trains and employs Masters', PhD, and Post-Doctoral research fellows in African institutions, creates content such a massive open online course (MOOC) on One Health, and has

Thematic Training Programs (TTPs) in five areas of One Health, specifically tailored for the diverse African context [13]. This is all in addition to hundreds of publications and reports released on zoonotic disease control and surveillance.

The evolution of this program is an excellent example of the necessary shifting of ownership from high-income funders and donors to local and regional experts. Due to the strong sense of local ownership, there is a commitment to priorities that are entirely relevant to the regional and local context, and there seem to be high levels of trust between partners. Even in the cases where partners from the global 'North' are involved, they have lived experience working in these countries, and have proven expertise in the matter that justify their involvement. As Erondu et al. emphasized regarding the 30 million USD partnership, "such a partnership to support Africa should be led from Africa by African scientists, partnering with Western institutions where appropriate, especially where capacity has been demonstrated" [8].

Afrique One-ASPIRE is an excellent example of African-led work with collaboration from northern partners when there is value added. In fact, the Afrique-One platform clearly identifies the areas in which each partnering institution provides support: with rabies control, for example, the laboratory infrastructure, diagnostic analysis, and training of veterinarians are all carried out by African institutions. Swiss TPH (Tropical and Public Health Institute) and the University of Glasgow provide links to other interdisciplinary research on the topic, connecting the work to the global landscape of rabies control and elimination [14].

As a field, global health practice needs to be transformed to truly achieve decolonization. Afrique One-ASPIRE is precisely the type of initiative scholars are insisting needs to be normalized and standardized: a locally-owned program, which invests in researchers, scientists, scholars, and practitioners in Africa, with priorities and agendas driven by those closest to the work. Instead of falling into more of the same unsustainable, removed engagement, global health practitioners may use Afrique One-ASPIRE as a model on how to support local actors for collaborative and mutually beneficial work.

Bibliography

1. S. Abimbola and M. Pai, “Will global health survive its decolonisation?,” *The Lancet*, vol. 396, no. 10263, pp. 1627–1628, 2020.
2. X. Kwete, K. Tang, L. Chen, R. Ren, Q. Chen, Z. Wu, Y. Cai, and H. Li, “Decolonizing Global Health: What should be the target of this movement and where does it lead us?,” *Global Health Research and Policy*, vol. 7, no. 1, 2022.
3. S. Abimbola, S. Asthana, C. Montenegro, R. R. Guinto, D. T. Jumbam, L. Louskieter, K. M. Kabubei, S. Munshi, K. Muraya, F. Okumu, S. Saha, D. Saluja, and M. Pai, “Addressing power asymmetries in Global Health: Imperatives in the wake of the covid-19 pandemic,” *PLOS Medicine*, vol. 18, no. 4, 2021.
4. M. Khan, S. Abimbola, T. Aloudat, E. Capobianco, S. Hawkes, and A. Rahman-Shepherd, “Decolonising Global Health in 2021: A roadmap to move from Rhetoric to reform,” *BMJ Global Health*, vol. 6, no. 3, 2021.
5. S. Abimbola, “On the meaning of global health and the role of Global Health Journals,” *International Health*, vol. 10, no. 2, pp. 63–65, 2018.
6. Aslanyan, G. TDR. (Host). (2022, February 8). *Global Health Matters: Actions for decolonizing global health* [Audio podcast]. Buzzsprout. https://www.buzzsprout.com/1632040/10020196
7. van der Zee B. Less than 2% of humanitarian funds ’go directly to local NGOs’. 2015 [cited 2020 Mar 13]. Available from: https://www.theguardian.com/global-development-professionals-network/2015/oct/16/less-than-2-of-humanitarian-funds-go-directly-to-local-ngos
8. N. A. Erondu, I. Aniebo, C. Kyobutungi, J. Midega, E. Okiro, and F. Okumu, “Open letter to international funders of Science and Development in Africa,” *Nature Medicine*, vol. 27, no. 5, pp. 742–744, 2021.
9. “Who establishes the Global Centre for Traditional Medicine in India,” *World Health Organization*, 25-Mar-2022. [Online]. Available: https://www.who.int/news/item/25-03-2022-who-establishes-the-global-centre-for-traditional-medicine-in-india#:~:text=This%20global%20knowledge%20centre%20for,of%20people%20and%20the%20planet. [Accessed: 14-Dec-2022].
10. P. Sharma, “Who global centre in Jamnagar will emerge as an international hub: PM modi,” *mint*, 19-Apr-2022. [Online]. Available: https://www.livemint.com/news/india/who-global-centre-for-traditional-medicine-in-jamnagar-will-emerge-as-an-international-hub-of-global-wellness-modi-11650388729922.html. [Accessed: 14-Dec-2022].

11. “Ayush,” *AYUSH | National Health Portal Of India*, 06-May-2015. [Online]. Available: https://www.nhp.gov.in/ayush_ms. [Accessed: 14-Dec-2022].
12. “Prime minister Shri Narendra Modi Lays foundation stone of WHO global center for traditional medicine at Jamnagar, Gujarat,” *Press Information Bureau*, 19-Apr-2022. [Online]. Available: https://pib.gov.in/PressReleasePage.aspx?PRID=1818164#:~:text=Tedros%20Ghebreyesus%2C%20Director%2DGeneral%2C,GCTM)%20in%20Jamnagar%2C%20Gujarat. [Accessed: 14-Dec-2022].
13. “About us - Afrique One,” *ASPIRE*, 2016. [Online]. Available: http://afriqueoneaspire.org/about-us/. [Accessed: 14-Dec-2022].
14. “TTP 1: Rabies - Afrique One,” *ASPIRE*, 2016. [Online]. Available: http://afriqueoneaspire.org/thematics/ttp-1-rabies/. [Accessed: 14-Dec-2022].